Haynes (I. S.)

A Clinical Paper on Some Cases with Various Interesting Features.

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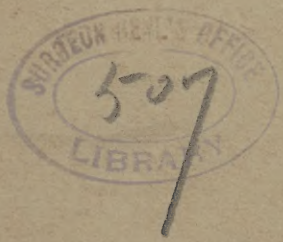

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A CLINICAL PAPER ON SOME CASES WITH VARIOUS INTERESTING FEATURES.*

1. Complete Inversion of the Uterus.
2. Fracture of the Radius immediately below the Bicipital Tuberosity.
3. Intestino-peritoneal Septicæmia.
4. Ventral Hernia.

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Case I. *Complete Inversion of the Uterus.*—Mrs. A. S., aged twenty-one years; first child on November 1, 1888; lived one day; mother made a speedy recovery.

Second child on October 26, 1889; born at 8.15 P. M.; delivered by a midwife, who left about 9 P. M. At 9.30 after-pains began, and became more severe from hour to hour until, about 2 A. M., they called for me (October 27th, Sunday).

On reaching the house, found a strong, healthy young German woman in great pain. Paroxysms every half minute, during which she cried out loudly, rolled from one side of the bed to the other, and bore down very hard. Morphine, a quarter of a grain hypodermically.

Examination.—On separating vulva and removing blood clots, exposed a large, round tumor that forcibly contracted and hardened with every pain.

* Read before the Society of the Alumni of Bellevue Hospital, October 4, 1893. For the discussion see page 643.

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Tumor as large as a large cocoanut, reaching just to vulva. Fingers passed all around it below; above it was attached by a broad pedicle to upper part of the vagina.

Abdominal palpation showed no uterus in pelvic region.

During the pains she bore down so hard that it seemed as if she would drive the entire contents of the abdomen through the vagina.

Diagnosis.—Complete inversion of uterus.

Treatment.—Midwife had returned after being sent for. She said she understood giving ether, so I had her start it while I administered a large, hot bichloride douche. The woman did not succeed with the ether, and I had to take the cone. While administering the ether with the left hand, the inversion was reduced by the other in the following manner:

The right hand was well covered with carbolized vaseline, and pressure made upon the lowest and most prominent part of the uterus with the ends of the fingers bunched together. Had to relinquish this manœuvre, as on very slight pressure the uterine tissue gave way, making a slight tear.

Then the last two sets of phalanges were flexed to a right angle and pressure made with their dorsal surface. Gradually the uterus was indented, and in about twenty minutes fully returned to its natural position. Ether stopped.

A hot intra-uterine bichloride douche (1 to 4,000) given.

Uterus semi-relaxed, reaching as high as the umbilicus.

It was constantly, but gently, manipulated for half an hour, and contractions resulted about every three minutes, but they were so feeble that hæmorrhage was feared any moment, but fortunately did not occur. At the end of this time the uterus became a little firmer, and, when it did contract, produced such severe pain that morphine was again given to full physiological effect.

About 4 A. M. the uterus became somewhat more relaxed. A hot douche was given with good results for a little while. As it showed symptoms of again becoming relaxed, half a drachm of ergot was administered every half hour.

By 6 A. M. the uterus was in fair shape, only partially contracted, however, and during contractions could be felt as high

as the umbilicus; between the contractions it felt like a boggy mass filling the pelvis.

A binder was applied, and ten grains of chloral and fifteen of bromide of sodium were to be given every hour if necessary.

At 10 A. M. the temperature and pulse were normal; the patient was fairly comfortable; did not complain of pain, but left iliac fossa exquisitely tender on touch.

Convalescence was uneventful and steady. The tenderness in iliac fossa left after a saline laxative had been given.

The temperature was highest, 100° F., on the third day, and became normal as soon as needless feather beds (used for blankets) were removed and a very hot room cooled down.

By the eighth day I found her up and nursing the baby. I ordered her to keep quiet. By the eighteenth day she was doing her own work and said she was as well as ever.

In looking for the ætiology of the case, I asked the old German midwife at the first breathing spell after the reduction of the inversion if she had allowed the "afterbirth" to come away by itself. "Why, no," said she. "I helped it along mit der shtring."

If this procedure did not produce the entire inversion, it undoubtedly started it by bringing down a part of the uterus into the grasp of the cervix.

The severity of the pains and the great straining and bearing down while the uterus was inverted were entirely unlike labor pains or any bowel tenesmus, and are peculiar, I think, to this affection alone.

The friability of the uterine tissues impressed me after making a hole in them by the blunt ends of my fingers. However, on turning a still broader surface to the uterus in the shape of the back of my fingers, the uterus was gradually reduced without any other rents being made.

From this experience, I believe it would be dangerous to use any of the instruments advised for this purpose, for

I am sure that if the utmost care was not used the instrument could be pushed right through the uterus.

If I had had an instrument in place of my fingers I should never have been aware of the laceration that resulted. I believe the hand is superior to any and all instruments for cases like this.

The prolonged flaccid condition of the uterus after reduction was no doubt due to muscular paralysis following its severe contractions in an abnormal position.

The freedom from hæmorrhage and the scanty discharge afterward were noticeable.

There was no fever whatever due to the accident, but 1·4° due to a hot room and excessive covering.

Occurrence.—Playfair gives the ratio of acute inversion to births as 1 to 190,000.

The symptoms, aside from the tumor, "profound nervous shock, severe abdominal pain and cramp, and bearing down." "Hæmorrhage is a frequent accompaniment," he says. In this case there was no shock to speak of, and no hæmorrhage before, during, or after the inversion.

Under reduction, he says, "the inverted portion of the uterus should be grasped in the hollow of the hand and pushed gently and firmly upward into its natural position."

The plan I used is said by McClintock to increase the bulk of the mass and so increase the difficulty of reduction.

In regard to the former opinions, I would ask you to get a large cocoanut—one five inches in diameter—and see how much pressure you can exert upon its sides by grasping it in the "hollow of the hand"; convert the case into one of inverted uterus and you will agree with me that this mode of reduction, while, perhaps, theoretically practicable, is practically impossible. In regard to the latter opinion, I would say that the reduction is easiest and more rational by denting the projecting fundus and so turning the uterus

back that the size of the mass to the state of the cervix does not make much difference within reasonable limits, for with the cervix just having expanded sufficiently for passage of the fœtal head, it will again expand under an anæsthetic and allow passage of the returning uterus and the hand of the operator.

Probably if I had had one of the large rubber bags and the accompanying force pump at the time, I should have used it, and possibly with complete success. But on the whole I think the hand is preferable, for you then know every change in the surroundings and do not have to go ahead in the dark.

The intra-uterine douches are very beneficial, as all agree, in promoting subsequent contraction. They acted well in this case, but their effect was not of long duration.

Case II. *Fracture of the Radius immediately below the Bicipital Tuberosity.*—Harry R., aged four years, July 8, 1891, fell from a bicycle on to right arm. Just how, not known.

Examination, a few minutes after the accident.

Voluntary movements of forearm and elbow lost. Forearm between pronation and supination at right angles to arm. If it is extended, a swelling appears about an inch below the bend of the elbow over the radius. At this point there is abnormal mobility and greatest pain, but no crepitus elicited.

Diagnosis.—As above.

Treatment. — Plaster-of-Paris splint applied, with forearm completely supinated and flexed to ninety degrees with arm.

New splint July 15th. Removed August 4th; union perfect.

Pronation and supination only one third and slight stiffness at elbow, which disappeared entirely after three or four weeks without interference, giving perfect movements at elbow and between the radius and ulna.

The authors all agree in stating that the accident is a rare one.

Treves, in his *Applied Anatomy*, states the symptoms: "When the radius is broken between the insertion of the biceps and pronator radii teres, the upper fragment is flexed by the biceps and fully supinated by that muscle and the small supinator. The lower fragment will be pronated by the two pronators and drawn in toward the ulna by means of those muscles."

This case illustrated these theoretical symptoms almost perfectly.

On extension of the forearm the upper fragment was retained in a position of flexion, and no doubt supination; the swelling over the forearm and just below the elbow was due to the projection forward of the upper fragment on extension; it disappeared on flexion. The hand was held in a position midway between pronation and supination.

The position of full supination was well borne—in fact, caused no inconvenience whatever, for the boy made no complaint at any time.

The stiffness in the forearm movements disappeared on allowing the child to use its arm without any interference.

I believe in the teaching of Professor Stimson, that the fear of joint ankylosis—ankylophobia—and the consequent passive motion kept up in season and out, is responsible for many cases of limited or even no motion after such injuries.

I believe in letting them entirely alone for a reasonable time, and let the patient use his limb to suit himself.

I have seen complete ankylosis at the elbow following a dislocation entirely recovered from in eight weeks without any treatment whatever.

Case III. *Intestino-peritoneal Septicæmia.*—Mrs. S., aged twenty-six years, February 21, 1892, delivered of a good-sized boy after a labor of about ten hours. At the beginning of the labor the ostium vaginæ would barely admit two fingers,

which caused considerable pain. The perinæum was dense and firm and was stretched intermittently by bearing downward and backward until three, then four fingers, and finally the whole hand was admitted. At the delivery the perinæum was only slightly nicked, but I am confident would have been split to the anus but for the intermittent stretching. This procedure was suggested in the *Record* or *Journal* by a writer. I can not find the article now.

Case progressed perfectly normal without a single bad symptom until the 28th—seven days after the confinement.

On the 28th, at 4 P. M., she had a severe chill. At 7 P. M., temperature, 104° F.; pulse, 150; respiration, 24. Very restless, face flushed, skin hot and dry, felt very badly, was afraid she was going to die.

Carbolic douches had been given morning and evening from the first. The lochia had been natural and without odor for the entire time. The bowels had not moved since the 26th.

Tablespoonful doses of Tarrant's aperient were ordered every hour until the bowels moved. Five grains of sulphate of quinine every four hours.

February 29th, 10 A. M.—Temperature, 104° F.; pulse, 150; respiration, 24. Symptoms not improved. Bowels had not acted freely.

Thinking that perhaps there might be some trouble in the uterus, I gave chloroform and curetted, but it was absolutely free from the least trouble whatever.

Intra-uterine douche of carbolic solution. Salines kept up. During the afternoon the bowels moved three times; 7 P. M., temperature, 103·4° F.; pulse, 120.

March 1st, A. M.—Temperature normal; bowels moved several times during the night. Feeling all right, but weak. Recovery uninterrupted.

Here is a clear case of self-infection from intestinal bacteria allowed to develop during two days of constipation and probably penetrating to the peritoneal cavity. Relieved by free saline cathartics. I do not think anything else had any bearing upon the treatment, except possibly

the carbolic douches might help to restrain bacterial action; but just as soon as the bowels began to act freely and afford free drainage from the abdominal cavity the symptoms began to mend. I believe that in these cases, even when the septicæmia is due to uterine infection, saline cathartics, plus the intra-uterine treatment, are the most useful means we have to prevent further infection.

Case IV. *Ventral Hernia.*—Mrs. B., aged about forty-five years. Large-sized woman; mother of large family.

In 1883, after birth of a child, noticed a lump between navel and pubes. This gradually increased in size without causing her any particular discomfort. Was reducible itself on lying down.

In 1885 began to wear a large pan-shaped abdominal truss that did not keep the rupture in place.

In 1887 she had an attack of obstructed bowel. Tumor came down, was painful, and the bowels constipated. The doctor called administered a cathartic, which acted. The attack only lasted two days, but the lump did not go away for two weeks.

The case was uneventful, excepting chronic constipation, until March 24, 1891, when the rupture again came down and could not be reduced. They called for me and I found the usual symptoms of an obstructed hernia. The hernia was larger than usual, she stated; was about six inches in diameter, circular in shape, and most prominent point about two inches above proper level of the abdominal wall; tender to touch; considerable pain. Attack brought on by hard work at lifting furniture, etc., in spring cleaning.

An eighth of a grain of morphine every hour if necessary. Hot poultices. Operation advised but not accepted. Bowels moved satisfactorily on the next day after a high injection and the tumor diminished in size, but a large, doughy mass remained behind.

She finally consented to the operation and was prepared for it with diet and whisky until the 28th, when, with the help of Dr. Bauer, Dr. O'Neil, and Dr. Welch, the operation was undertaken.

All precautions against shock and sepsis taken.

Usual incision. Sac opened at once; consisted only of peritonæum and skin closely blended and much thinned from pressure.

A dark mass of omentum exposed. It was attached by its base to the sac all about the hernial orifice.

Adhesions broken down and omentum examined for contained intestine, but none found. The omentum from the congestion and hyperplasia was nearly half an inch thick and, when spread out, six or eight inches wide along its outer margin, being, of course, fan-shaped. It completely filled the opening of the sac.

It really looked as if a process of degeneration had begun in it, and it was deemed best to remove it. This was accordingly done in the usual manner by several interlocking silk ligatures. Pedicle examined for bleeding points; none being found, it was returned to abdomen. Opening of hernia circular and about an inch in diameter. The sac for a distance of about two inches around the orifice was dissected up and its neck freed from the fibrous ring. Neck of sac tied off by a heavy silk ligature and the rest cut away. The margins of the ring were brought together with heavy buried silk sutures. The redundant portions of skin removed and the edges sutured. Drainage tube inserted. Heavy dressing applied.

Convalescence progressed favorably with some little fever. On the fifth day superficial sutures and tube were removed. Union firm. The external wound closed up, yet there was some pain about the seat of operation and a degree or two of fever.

About two weeks later a definite point of fluctuation below and to the right of the incision was detected. This abscess was opened and a drachm or two of pus evacuated, in which was one of the deep sutures. This abscess discharged until all the deep sutures were removed. It then closed up and left only a small scar. The sutures were divided and taken out as fast as they appeared; a probe curved at the end was used to nook them into the wound so they could be removed. Patient was up and around the house during this time. After the last

suture was removed the sinus closed and she wore a light bandage, which she continued for some months.

There was no return of the rupture until the spring of 1893 —about two years—when she said a small lump appeared. Had not been wearing bandage for over a year. She was ordered to resume its use.

September 30, 1893.—Examination: She states rupture comes down, but she can replace it. She can not find the opening, however. When fully distended, rupture as large as a small orange. The rupture was not down at the time of examination. The orifice of the hernia was found, but would not admit any of my fingers. It is situated half way between umbilicus and pubes in median line. On coughing, a small knuckle of gut is forced out, but immediately returned to abdominal cavity on slight pressure.

Another operation advised with pretty sure hopes of cure, but she has all she wants of operations, she says Bandage advised and a truss later if she can not get along.

If no operation had been done it is possible that the mass of omentum might have become so adherent to the ring as to close it up and produce a cure; yet the dangers of intra-omental hernia would have remained. On the other hand, the omentum might have sloughed, for it was very dark and congested. If the ring had been closed by perfectly aseptic catgut sutures the suppuration would have been omitted. It is probable that one or more of the sutures carried the infection. At any rate, the wound did not close until the last of them was removed. Yet all this time the silk on the pedicles of the omentum and peritonæum gave no trouble, and the cutaneous incision, also sutured with silk, closed without suture abscesses.

The suppuration had nothing to do with the return of the hernia, to my mind, for the reason that the granulation tissue formed on cicatrizing would aid in closing the orifice. If, however, the orifice gaped and the connective tissue alone remained, a weak spot was surely left.

Doing the operation again I would still use silk, but would redouble all antiseptic efforts.

The woman is well to-day and the operation has served to clean out all the omentum and to give us a hernia with a small orifice—a favorable condition for operation, but much more dangerous for the woman.

After the operation there was freedom from a hernia for nearly two years.

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